‘Current Training in Obstetric Anaesthesia – Can It Be Improved On and How So?’

Introduction

Obstetric anaesthesia is an anaesthetic sub-specialty that in my experience can be both challenging and rewarding. Anaesthetic trainees need to learn and develop technical skills including spinal and epidural anaesthesia and employ non-technical skills including communication, teamwork and stress management to succeed in this environment that is quite distinct from general theatres.

How can training be improved to better prepare and better support trainees working in this environment? I had a clear idea of how I wanted to answer this essay question. But instead of launching into a monologue based on my own experience, I decided it would be a lot more informative and meaningful to take a straw poll of anaesthetic registrars and use this as the basis of my argument. I sent an anonymised survey using Surveymonkey.com with thirty multiple choice questions to 27 anaesthetic registrars, I had 20 completed surveys which is a response rate of 74%.

The results of my survey are really provocative and illustrate a problem: A significant number of trainees experience emotional hardships and stress working on call in obstetric anaesthesia combined with few management strategies and poor preparation to address this. Interestingly the same survey also pinpoints areas for change and practical solutions to these problems which are supported by the trainees themselves and could be implemented at a national and local level and incorporated into the formal curriculum in its 2020 update.[1]

It is worth considering that although my survey is small, its' finding that a large proportion of anaesthetic trainees experience occupational stress and emotional hardships is in keeping with The Royal College of Anaesthetics (RCOA) Report 'A Report On The Welfare, Morale and Experiences of Anaesthetists in Training: The Need to Listen' based in part on a survey of trainees between December 2016 and January 2017 with responses from 58% of anaesthetists in training.. 61% of respondents felt their job negatively affected their mental health and 21% reported that this occurred frequently.[2] The GMC in 'The State of Medical Education and Practice in The UK 2018' acknowledge that action is needed to address mounting pressures, stress and burnout in the workplace that are affecting "training environments and the ability of doctors to do their jobs".[3] Anyone intending to improve training in obstetric anesthesia should not ignore the elephant in the room!

The GMC Report identified four areas where doctors themselves have said that they need support: prioritisation of mental and physical health; support and mentoring from colleagues and managers; promotion and protection of continuing professional development (CPD) and other non-clinical activities, which must include protected teaching time for trainers and mentors; and implementation of work based support systems.[3] I have adopted these categories and used them to structure my essay into the following sections: Stress working in obstetric anaesthesia, emotional support for trainees at work, demands on trainers and mentors, solutions directed at the trainee, solutions directed at the workplace environment and culture. I have made reference to my survey results under each of these titles below.

Stress Working in Obstetric Anaesthesia

A number of trainees reported stressful experiences working on call in obstetric anaesthesia. 16/20 (16 out of 20) anaesthetic trainee respondents have had a traumatic experience when on call for obstetric anaesthesia. 13/20 feel stressed frequently or some of the time when on call for obstetric anaesthesia. 16/20 say they have taken work stress or negative emotions related to work home at the end of the day.

Epidural anaesthesia has been identified as a source of stress by trainee members of The OAA in a survey issued to all trainee members in May 2012 and published in 2015.[4] When asked about early training experience 66% respondents said that they found performing epidurals was very stressful, with 36% indicating that they felt uncertain a lot of the time, and 25% said they felt under considerable time pressure from midwives/ODPs.

In my survey 11/20 respondents said they felt feelings of shame or inadequacy related to their ability to do their job on obstetric anaesthesia either sometimes or frequently and 15/20 have felt shame when calling a colleague for help with a procedure. I asked respondents to imagine the situation where they are unable to do an epidural and decide to call for help from another anaesthetist. The mean stress score on a modified Likert Scale was 6 out of 10 when calling for help. I asked respondents to score their stress before the procedure, on the last attempt, when calling for help, an hour later, at the end of the shift before going home and after arriving home. It was concerning to note that although the mean stress score dropped at each time point after calling for help, it did not drop to the pre-procedural level even after the trainee arrives at their home. Interestingly the standard deviation was high: Some trainees

reporting low stress scores at all times, indicating that trainees are different and have different needs.

Why do trainees feel stress when they are unable to do a procedure? The Association of Anaesthetists of Great Britain and Ireland published 'Stress in Anaesthetists' in 1997,[5] this report identified 'The problem of distorted thinking', namely that anaesthetists have very high expectations of themselves and have a tendency to magnify mistakes and minimise successes, which may be associated with feelings of inadequacy. My survey revealed that 15/20 trainees admitted to magnifying mistakes and minimising successes. 10/20 trainees struggling with a procedure would primarily consider themselves to be responsible rather than attributing this to patient or environmental factors and 3/20 were unsure. It is important to encourage trainees to celebrate their successes and not dwell on negative experiences from the past when these hold no further educational value.

Trainees have high expectations of themselves and their peers. When asked what percentage of patients they feel an anaesthetist of their grade should be able to successfully cannulate and what percentage of obstetric patients should be able to do an effective spinal for, the modal groups were 99-100% and 90-95% respectively. I do not have data for the actual failure rate for the same trainees who work at different institutions, so I cannot comment on these numbers as being overly optimistic or realistic. However these rates can be compared with institutions' published absolute spinal failure rates with range from 17 to <1%,[12] and studies which investigated the use of cumulative sum analysis to assess trainees learning spinal anaesthesia, here departmental consensus set an acceptable failure rate of 10%,[7] and 15%.[8]

Perfectionism is a risk factor for burnout,[9] and perfectionist beliefs should be challenged as unrealistic and harmful to the individual. It is also important to remove the stigma around calling for help and remind trainees that, just like their trainers, they will not always be able to do a procedure and that this is OK. I recall how I found it helpful when a consultant pointed out to me that the reason he was so good at spinals was probably because he had done about 10000, far more than I had done or attempted. It may be helpful for consultant trainers to actively check-in with trainees after they encounter difficulty with a procedure, perhaps after a break, to ask how they feel about it, to share their realistic expectations, and to offer a reality check.

Studies have described the use of cumulative sum analysis and being videotaped performing epidurals in an attempt to rigorously assess trainee performance and assess proficiency.[7,8,10] It is easy to see how in today's medicolegal climate efforts are being made to optimise assessment tools, however such close observation may exacerbate trainee stress and actually hinder performance. I can only imagine the psychological experience of the trainee who was asked to plot a cumulative sum graph, adding a point for each epidural, who required 185 epidural attempts for their graph to cross the line indicating an acceptable failure rate![7] I am sure 'gruelling' does not do it justice. These studies have shown that some trainees take a lot longer than others to learn procedures.[7,8]

One very good experience I had as a trainee when starting in obstetrics was that after a short period of close supervision my consultants offered me space to do epidurals and manage Caesarean Sections independently, but making it clear to me that whenever I wanted or needed them to stand next to me and support me they would. I am also grateful that although

I am sure the department kept tabs on my epidural re-site rate, midwife and patient satisfaction as markers of my progress when starting in obstetrics, I was not made aware of such scrutiny.

Emotional Support for Trainees at Work

Only 7/16 trainees who had a traumatic experience on call for obstetrics ever discussed how the experience made them feel with a consultant anaesthetist, whereas 12/20 said that if they had a traumatic experience at work they would want to be able to discuss how it made them feel with a consultant anaesthetist. 12/20 think there is a stigma associated with talking about emotions with consultant anaesthetists but only 3/20 think there is a stigma when doing the same with trainees. 11/20 think that trainers would think less of or judge a trainee negatively if they admitted to feeling very upset about or distressed by an experience in the workplace.

In view of the fact that trainees feel unable to share their emotions with consultants and in view of the disruption of peer support networks caused by frequent trainee moves from hospital-to-hospital during training, opportunities for trainees to spend time together should be maximised. This includes promoting synchronous trainee coffee breaks as championed by The Group of Anaesthetists in Training (GAT),[11] and the organisation of trainee socials. WhatsApp provides a great communication tool for trainees to communicate and facilitates planning of synchronised breaks. In my experience it is uncommon for anaesthetic trainees to have lunch or breaks together in a group. Reasons include: no fixed break time, unpredictable clinical workload, poor planning and communication among trainees. We prioritise learning opportunities, patients and work over our own wellbeing, social lives, hydration, breaks and food,[2] our workplace culture supports this view. Sometimes a job

cannot wait, but often it is appropriate to wait 20 to 30 minutes to perform a procedure or other job and we should feel empowered and supported by our senior colleagues to communicate to the person contacting us that we cannot come at the moment because we are eating lunch or drinking a coffee but that we will come after this.

It is also probably important to appoint departmental leads in obstetric anaesthesia who are caring and interested in trainee welfare. When asked whether they felt their consultant trainers care about them and their wellbeing, 5/20 respondents said yes and 15/20 said some do. It is important that consultants are aware of how they as a workforce are perceived and it may be useful for them to reflect on the experience and emotional needs of junior and more senior trainees, which may bear similarities to their own past experiences.

Demands on Trainers and Mentors

It is also worth considering the implication for trainees of trainers who are overburdened with service pressures including: overbooked lists, unplanned overruns, on-call commitments and changing expectations.

The 2016 RCOA Membership Survey received over a thousand free text responses to the question “Is there anything that makes it harder for you to deliver safe and effective patient care?” These were assigned by qualitative analysis to four themes: lack of qualified staff, inadequate facilities, disengagement and lack of co-operation, demoralised and fatigued workforce.[12] These themes demonstrate a lack of resources which we know causes burnout, and also illustrate the effects of burnout.in the anaesthetic workforce.

Over a quarter of trainers feel that they don't have enough designated time to train, and that the time they do have is not always sufficiently protected.[13] Trainers cannot deliver effective training or mentorship if they are not allocated time. More poignant is that, by admission, trainers' demands on them as teachers outstrip the resources, including time, specifically earmarked for this purpose. When considered in isolation this situation where demands exceed resources could put anaesthetists who opt to be more heavily involved in education at a higher risk of burnout.[14] We are all familiar with the skill with which rota coordinators redistribute resources to plug last minute rota gaps, but sometimes hard choices may need to be made such as cancelling an elective list to allow a planned consultant-led teaching session to go ahead.

This status quo, as it stands, may discourage anaesthetic consultants from choosing to offer teaching sessions which they are not compensated for or dissuade them from actively engaging with teaching trainees.

Trainers also serve as role models and mentors to junior anaesthetists. However the overburdened trainer, who finds it hard to deliver safe and effective patient care in the current system and who may themselves face stresses and strains in the workplace and at home in their own lives, may shy away from voluntarily taking on a mentoring role.

Solutions Directed at the Trainee

11/20 respondents felt that trainers and training programme did not do a good job of preparing them for the stress and/or emotions associated with working as an anaesthetic trainee in obstetric anaesthesia.

The importance of preparing our trainees for on-calls and supporting them to deal with stress and negative emotions relates to trainee wellbeing at work and at home, to minimising sickness absences, to trainee retention in anaesthetics but also to trainee performance at work.

I was surprised that my survey revealed that as many as 9/20 of respondents had employed either a breathing technique, mindfulness or meditation to manage stress or emotions at some point in their lives. 11/20 felt there was a benefit to be gained for anaesthetic trainees from these practices, and 13/20 would choose to attend a session led by an expert in these practices during work hours. I am aware of trainee cynicism regarding interventions labelled 'resilience training' which are currently in vogue, so I asked the question: 'Do you think it is possible to teach or enable another individual to develop skills, techniques or strategies which actually help them to manage stress and/or emotions?' 13/20 answered yes to this question. I also asked if trainees thought that individuals championing 'resilience training' were doing so primarily because they care about trainee welfare and wellbeing: only 6/20 said yes, with 14/20 saying no or unsure. Perhaps trainees are aware that research shows that to tackle work stress and burnout effectively, we need to modify the working environment and culture, and not just focus on promoting resilience in the individual.[9]

Clearly any intervention designed to improve trainee welfare or wellbeing needs to be carefully thought out both in terms of content and its presentation and branding. Small studies have shown that it is feasible to deliver mindfulness training programmes to working doctors over multiple weeks either in the format of a formal training programme,[15] or by encouraging self-directed use of a smartphone app.[16] 'Headspace', a smartphone application with over 30 million members, was used in the pilot study by resident doctors, including anaesthetists. In this study wellness parameters and mindfulness measured using The Freiburg Mindfulness Inventory increased. Using a popular existing smartphone application guarantees high quality, user-friendly content, and increases flexibility, choice and control for the user.

Solutions Directed at the Workplace Environment and Culture

Research shows that to tackle work stress and burnout effectively, we need to modify the working environment and culture, and not just focus on promoting resilience in the individual.[9] I have already discussed some cultures that I think should be encouraged: supporting trainees to take breaks together, supporting trainers to deliver teaching and mentorship, positive feedback, a non-judgemental atmosphere, challenging perfectionism and making efforts to remove the stigma associated with calling for help.

Working in a multidisciplinary team, especially one which may be unfamiliar, brings its own stresses and strains. I attended The Practical Obstetric Multi-Professional Training (PROMPT) Course in January. The course increased my awareness of my obstetric and midwifery colleagues' roles and responsibilities and the strains and stresses that they are often under, which I might have been unaware of. On the breech and twin per-vaginal delivery stations I had the rare opportunity to observe my colleagues' delivery skills in

action. Hearing community midwives discussing their management of PPH in the community when working in remote locations as a lone practitioner was really eye opening. There's something about all sitting side-by-side like school kids in home clothes that really breaks down inter-professional boundaries and this course has increased my respect and consideration for my non-anaesthetic colleagues.

Schwartz rounds involve staff members talking in front of their colleagues about difficult clinical experiences and how they made them feel. Schwartz rounds have been supported as an intervention to improve staff wellbeing and potentially protect against burnout.[1,17] Attenders report a positive impact on themselves, their relationships with colleagues and with patients.[18] In my survey, 14/20 respondents said that when discussing clinical cases with consultant anaesthetists the emotional or affective component is rarely discussed. As already mentioned a number of respondents said they would want to be able to discuss how a traumatic event made them feel with a consultant anaesthetist. Most respondents said it would be useful to hear that other colleagues encounter difficulties at work with procedures, stress or experience strong emotions. This demonstrates that sharing difficult events with colleagues has the potential to benefit the listener as well as the individual choosing to share. Clearly trainees derive reassurance from knowing that others' experiences are similar to their own.

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